

Health Services for Children in Foster Care

A policy brief from the study of Health Services for Children in Foster Care.



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Medicaid and Financing of Health Care for Children in Foster Care: Findings from a National Survey

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Many children in the child welfare system have physical and emotional problems resulting from abuse or neglect and are at greater risk for poor physical and mental health due to their prior experiences (Schor 1988; Szilagyi 1998; Simms 2001; Halfon, Mendonca, and Berkowitz 1995; Halfon, Berkowitz, and Klee 1992). Moreover, children's well-being can deteriorate if the foster care placement is not well suited to their needs or appropriate health services are not provided. Studies show that children in foster care have much higher rates of asthma, neurological problems, dental problems, learning problems, and developmental delay than other children (Simms, Dubowitz, and Szilagyi 2000; Zima et al. 2000; Szilagyi 1998, Halfon et al. 1995). About 60 percent of children in foster care have a chronic medical condition while 25 percent have three or more chronic problems (Szilagyi 1998; Halfon et al. 1995). Moderate to severe mental health and behavioral problems affect 50-80 percent of children, and about 60 percent of preschool age children in foster care have developmental delay (Szilagyi 1998; Halfon et al. 1995). Up to 60 percent of youths in foster care have at least one psychiatric disorder (dosReis et al. 2001, Szilagyi 1998). One study estimated that fewer than 5 percent of children in foster care are free of psychological symptoms (Swire and Kaveler, 1977).

These multiple complex health needs require preventive, diagnostic, and treatment services as well as care coordination. Studies show that children in foster care use more health and mental health care than other children with

similar socioeconomic status (Kortenkamp and Ehrle 2002; dosReis et al. 2001; Takayama, Bergman and Connell 1994; Halfon, Berkowitz and Klee 1992a, 1992b). Despite the relatively higher use of health services, children in foster care have significant unmet health and mental health needs (Schor 1988; Halfon and Klee 1987). For example, although about 60 percent of children in foster care have moderate to severe mental health problems, only about 25 percent are receiving services at any point in time (Halfon, Berkowitz, and Klee 1992b). Most children in foster care receive services from the same fragmented and under-resourced health system used by other low-income children (Halfon et al. 1994).

Despite needs created by acute and chronic health and mental health problems, not all essential services for this group of children are easily accessed through Medicaid (Rosenbach 2001; Bergman 2000). Adequacy of health care financing affects children's access, waiting time for services, and care coordination (AAP 2002). Medicaid (including the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program) is the primary payer of health, dental, and mental health services to children in foster care. Although most children in foster care are eligible for Medicaid, historically states have not taken full advantage of Medicaid and EPSDT to fund children's health, developmental, and mental health services (Rosenbach, Lewis, and Quinn 2000). State Medicaid options for eligibility and reimbursed services also create variation in access to Medicaid services across

states. Not all states automatically extend Medicaid eligibility to children in foster care placement. Studies have also shown that some children lose coverage when they leave foster care and return to the parent. For example, a recent study of Medicaid claims and eligibility found that between one-third and one-half of children leaving foster care are no longer enrolled in Medicaid after one month (Rosenbach et al. 2000). This can disrupt ongoing care and can jeopardize children's well-being and permanency in the family. Both well-being and permanency are key outcomes for child welfare systems.

Thus Medicaid eligibility, its coverage of services, and payment are key for meeting children's health care needs. As a result, child welfare and health agencies are increasingly focused on the impact of Medicaid financing on health care access and quality. Recent federal legislation (The Adoption and Safe Families Act (ASFA) of 1997) mandates that child welfare agencies work with other community agencies to evaluate and continually improve foster children's access to health and mental health services. In addition, under the Child and Family Services Review (CFSR) process implemented in 2000, state and federal child welfare officials assess state performance on service systems and on outcomes for children in foster care and their families (ACF 2002; 1999). The outcomes that are reviewed in this process include children's receipt of adequate services to meet their physical and mental health needs. The review process also evaluates systemic service system factors within the state. This includes the state's capacity to provide needed health and mental health services.

At the same time that states are focusing on more systematically improving delivery of health and mental health services to children in foster care, Medicaid programs are making significant changes to their delivery systems that may affect access to services. In recent years, state Medicaid programs have implemented significant change and innovation in delivering health and behavioral health services. Prepaid capitated financing and the provider networks created by Medicaid managed care expansions have altered systems of medical and mental/behavioral health. Most children in foster care receive

services from the same community-based providers that serve low-income and publicly-insured children and that are affected by managed care transitions. Most of these new prepaid delivery models have not been fully evaluated to determine their impact on access to services for children during their entry to foster care, placement, and exit from protective custody. Key health care financing issues for foster children continue to include Medicaid eligibility, enrollment and retention procedures, benefit limitations, payment mechanisms, transition procedures upon return to the biological family, use of managed care, and payment adequacy, among others.

This brief presents a national overview of financing policies and their impact from the perspectives of state Medicaid, child welfare, and mental health agencies. We evaluate Medicaid policies on eligibility, enrollment, retention, and coverage of physical as well as dental, developmental, and mental health services for children in foster care. We compare the perspectives of state child welfare agencies and state Medicaid programs on eligibility and coverage. This brief evaluates (1) Medicaid eligibility policies and procedures; (2) covered services; (3) use of non-Medicaid payment sources for basic dental, health, developmental, and mental health services; and (4) payment policies and impact of Medicaid managed care.

METHODS

Findings are based on surveys of administrators in state Medicaid programs, child welfare agencies, mental health agencies, and child health agencies. Surveys were completed in 1999-2000 by agency directors in the 50 states and Washington, D.C. and by directors in the largest counties nationally. The response rate among state agencies was 80 percent (Halfon et al. 2002a). This includes 40 Medicaid, 38 child welfare, 44 child health, and 42 mental health agencies.

The study was funded by the Maternal and Child Health Bureau (MCHB) and was initiated as part of a MCHB partnership with the Administration for Children and Families (ACF) with advisory input from the Public-Private Partnership Subcommittee of a Technical Advisory Group

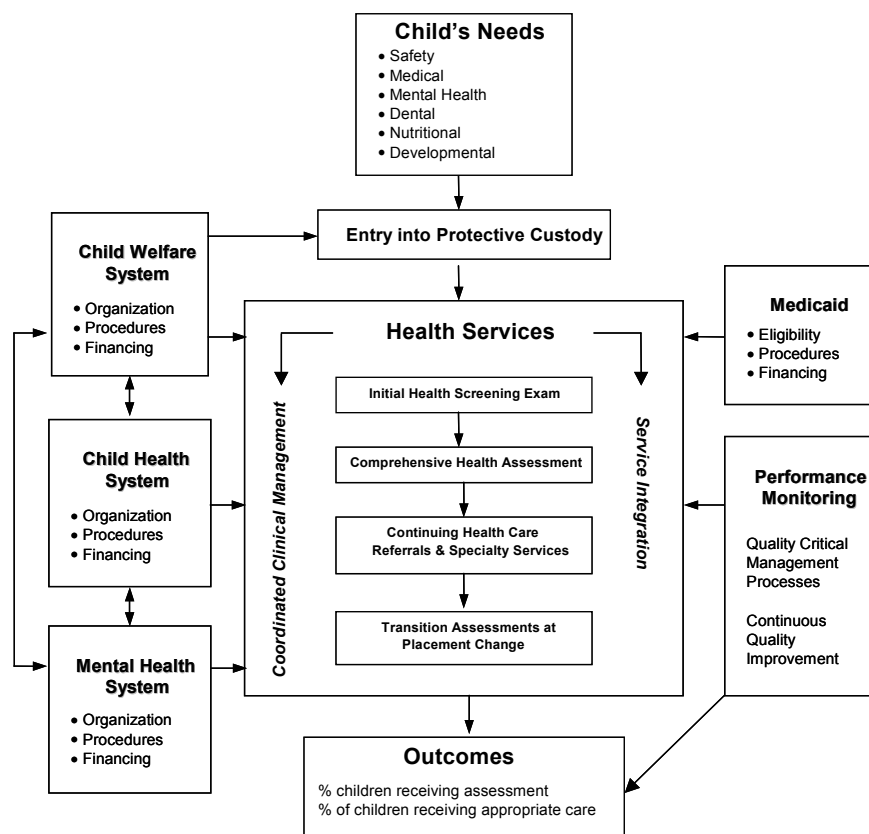
convened by MCHB and ACF. Federal partners include the ACF, the Centers for Medicare and Medicaid Services (CMS), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Surveys were developed and fielded by the National Center for Infant and Early Childhood Health Policy at UCLA that is funded by MCHB.

Survey measures were developed from organizational best practices issued by the Child Welfare League of America (CWLA) and the American Academy of Pediatrics (AAP). The CWLA developed standards in 1988 for health care to children in foster care. The AAP issued similar standards in 1994 and re-affirmed these standards in 2002. The American Academy of Child and Adolescent Psychiatry has issued similar guidance on mental health services for children in foster care (AACAP, 2001). The CWLA-AAP standards show state and local child

welfare agencies how to systematize health care for foster children (Simms et al. 1999).

Figure 1 depicts how the structure and policies of state agencies influence children's access to health care based on the CWLA-AAP standards. Prior studies show that financing and health care organization policies can promote health care access (Shortell et al. 1996) and specifically for children in child welfare (Simms et al. 2000; Schneider and Fennel 1999; Halfon et al. 1992c; Takayama et al. 1994). Performance monitoring is now expected of most public agencies (GAO 2001). It is also consistent with the intent of the new Child and Family Services Review (CFSR) requirements for state child welfare agencies (HHS 2002). Assessing access to health and mental health services is an important interagency process because multiple agencies (e.g., Medicaid, child welfare) set policies that affect children's access to services.

Figure 1 Health Care Delivery Model for Children in Foster Care

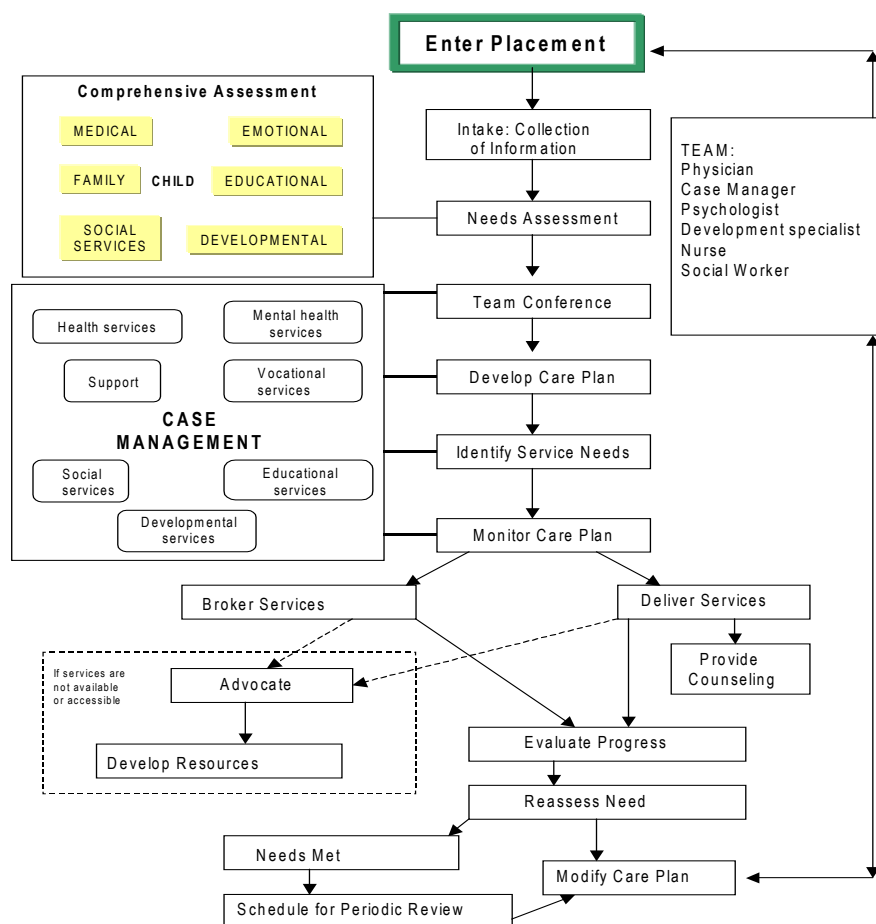


Halfon, Inkelas, Flint et al. 2002

Figure 2 shows the assessment, diagnosis, ongoing services, and care coordination services that should be available to children in foster care (Halfon, Berkowitz, and Klee 1992). It outlines the key processes along with the providers that are involved from intake through the processes of ongoing care and periodic re-assessment of health and mental health needs. To understand

whether or not key financing elements are in place in a state, child welfare agencies need to understand how Medicaid can and should be used to fund this scope of services. Systematic state-level analysis of funding for these services shows whether or not states and counties have the funding mechanisms in place.

Figure 2 Health/Mental Health Services and Care Coordination Requirements for Children in Foster Care



Halfon, Berkowitz, and Klee 1992c, Halfon, Kaufman, Perez et al. 2001

FINDINGS

Medicaid Eligibility and Enrollment

CWLA standards call for child welfare and Medicaid agencies to streamline Medicaid eligibility procedures to ensure timely provision of needed health services. Sometimes a child's eligibility takes time to establish due to the sudden removal from the biological parent. Many children have urgent health or mental health needs, and the CWLA health standards call for an initial health screening within 24 hours of removal from the biological parent. Federal regulations allow state Medicaid programs to authorize payment for immediate health services for children entering placement if the state adopts a policy to "presume" such children eligible for Medicaid. This provision guarantees payment for the initial services provided after separation from the parent.

Findings from our survey of state agencies show a discordance between the eligibility policy reported by the state Medicaid agency and Medicaid policy as reported by child welfare agencies. Our findings show that few Medicaid agencies (15 percent) have a formal presumptive eligibility policy for children entering out-of-home care. This is consistent with another recent state survey of Medicaid policies (Rawlings-Sekunda 1999). Yet more than 50 percent of state child welfare agencies report that their state Medicaid program has a presumptive eligibility policy for children in foster care. This shows that many child welfare agencies are not accurately describing their state's Medicaid policy on presumptive eligibility and thus may not be aware of the Medicaid eligibility provisions in their state.

CWLA and AAP standards also call for extended Medicaid eligibility through a post-placement period, to the extent permitted by federal law. This is because a child's return to the biological parent can result in discontinuation of needed health and mental health services, as well as an end to the health monitoring that occurs while the child is in protective custody. Continuity in services is important for sustaining the improvements made while in foster care and can be jeopardized if Medicaid coverage ends.

Children's health and mental health are important aspects of their well-being and their ability to stay in parent custody.

Our findings show that fewer than 25 percent of state Medicaid agencies automatically extend Medicaid coverage to children leaving placement. Several of these states note that the process is automatic only for children who are adopted. One reports having an optional eligibility category that extends coverage to those children leaving placement who require services to remain at home and would not otherwise have access to these services. Four state Medicaid agencies specify the time period for this automatic post-placement eligibility, with maximum eligibility ranging from one (1) to twelve (12) months.ⁱ

Covered Services within Comprehensive Health Assessment Exams

CWLA-AAP standards call for a comprehensive health assessment within 30 days of placement that include medical, mental health, dental, and development assessments. This timing permits child welfare caseworkers and health care providers to gather the necessary information to conduct a truly comprehensive assessment and construct a responsive health care plan for the child while in protective custody.

In our surveys, state Medicaid agencies report that their Medicaid and/or EPSDT programs cover nearly all essential components of the comprehensive assessment. Each of the following services is reimbursed by 85 percent or more of states: vision assessment, hearing assessment, dental exam, developmental assessment, mental health assessment, physical health assessment, general lab tests, and specific lab tests. However, Medicaid agencies often report that they do not routinely reimburse several other components of the comprehensive health assessment that CWLA-AAP standards recommend. About 21 percent of states do not reimburse for the collection and review of past health history, 44 percent do not reimburse for a written summary of exam results, and 69 percent report not reimbursing for a school readiness assessment.

Use of State and Local Funds for Health Care Services

Use of non-Medicaid public funds to pay for Medicaid-eligible services, or to supplement Medicaid payments, shows the effectiveness of state Medicaid programs in meeting health needs of children in foster care. State child welfare and Medicaid programs were asked about sources of funds for basic health and mental health assessment and treatment services; their views of Medicaid reimbursement adequacy; and the use of child welfare funds to supplement insufficient Medicaid coverage.

State Medicaid and child welfare programs in nearly all states report that Medicaid and EPSDT are routinely used for the core services. However, reports about how well Medicaid and EPSDT funding covers core services for children in foster care show that states use multiple funding sources. Many agencies use other state and local funds for health services that are potentially reimbursable as Medicaid/EPSDT benefits. Both Medicaid agencies (**Table 1**) and child welfare agencies (**Table 2**) report use of multiple funding sources.ⁱⁱ For example, health care case management is reported as not routinely reimbursed by Medicaid or EPSDT by

Table 1 Funding Sources Routinely Used for Foster Children's Health Care, As Reported by State Medicaid Agencies

	Medicaid and/or EPSDT (%)	Medicaid (Non-EPSDT) (%)	EPSDT (%)	Title IV (%)	Title V (%)	Other State Funds (%)	Other Local Funds (%)	Other Funds (%)	N
Initial health assessment	94	56	64	0	8	14	6	6	36
Comprehensive health assessment	97	63	66	0	9	14	6	6	35
Mental health assessment	97	65	53	3	0	15	6	9	34
Ongoing mental health treatment	97	71	47	3	0	18	9	9	34
Developmental assessment	94	55	61	0	6	24	12	9	33
Developmental intervention	90	58	55	0	0	19	10	10	30
Dental assessment	97	65	56	0	6	15	3	6	34
Dental treatment	97	68	53	0	6	15	3	6	34
Health care case management	87	65	42	6	3	23	6	6	31

Source: UCLA calculations from the 1999/2000 Assessment of Factors Influencing the Adequacy of Health Services to Children in Out-of-Home Care

Note: Shows percentages of Medicaid agencies that report routine use of a funding source to pay for services for foster children in their state. Based on responses from Medicaid agencies. N is total agencies responding to the item. Agencies can identify multiple funding sources for a given service. Category of "Medicaid and/or EPSDT" is a composite denoting use of Medicaid, EPSDT, or both.

Table 2 Funding Sources Routinely Used for Foster Children's Health Care, As Reported by State Child Welfare Agencies

	Medicaid and/or EPSDT (%)	Medicaid (Non-EPSDT) (%)	EPSDT (%)	Title IV (%)	Title V (%)	Other State Funds (%)	Other Local Funds (%)	Other Funds (%)	N
Initial health assessment	94	70	79	12	0	39	21	6	33
Comprehensive health assessment	97	69	80	20	0	37	23	3	35
Mental health assessment	94	89	49	17	0	46	29	6	35
Ongoing mental health treatment	97	97	34	29	0	57	31	11	35
Developmental assessment	94	71	66	14	6	37	11	9	35
Developmental intervention	89	74	37	17	6	46	17	14	35
Dental assessment	97	80	57	9	3	34	17	11	35
Dental treatment	94	91	37	9	3	46	17	11	35
Health care case management	80	72	24	16	0	24	0	8	25

Source: UCLA calculations from the 1999/2000 Assessment of Factors Influencing the Adequacy of Health Services to Children in Out-of-Home Care

Note: Shows percentages of child welfare agencies that report routine use of a funding source to pay for services for foster children in their state. Based on responses from child welfare agencies. N is total agencies responding to the item. Agencies can identify multiple funding sources for a given service. Category of "Medicaid and/or EPSDT" is a composite denoting use of Medicaid, EPSDT, or both.

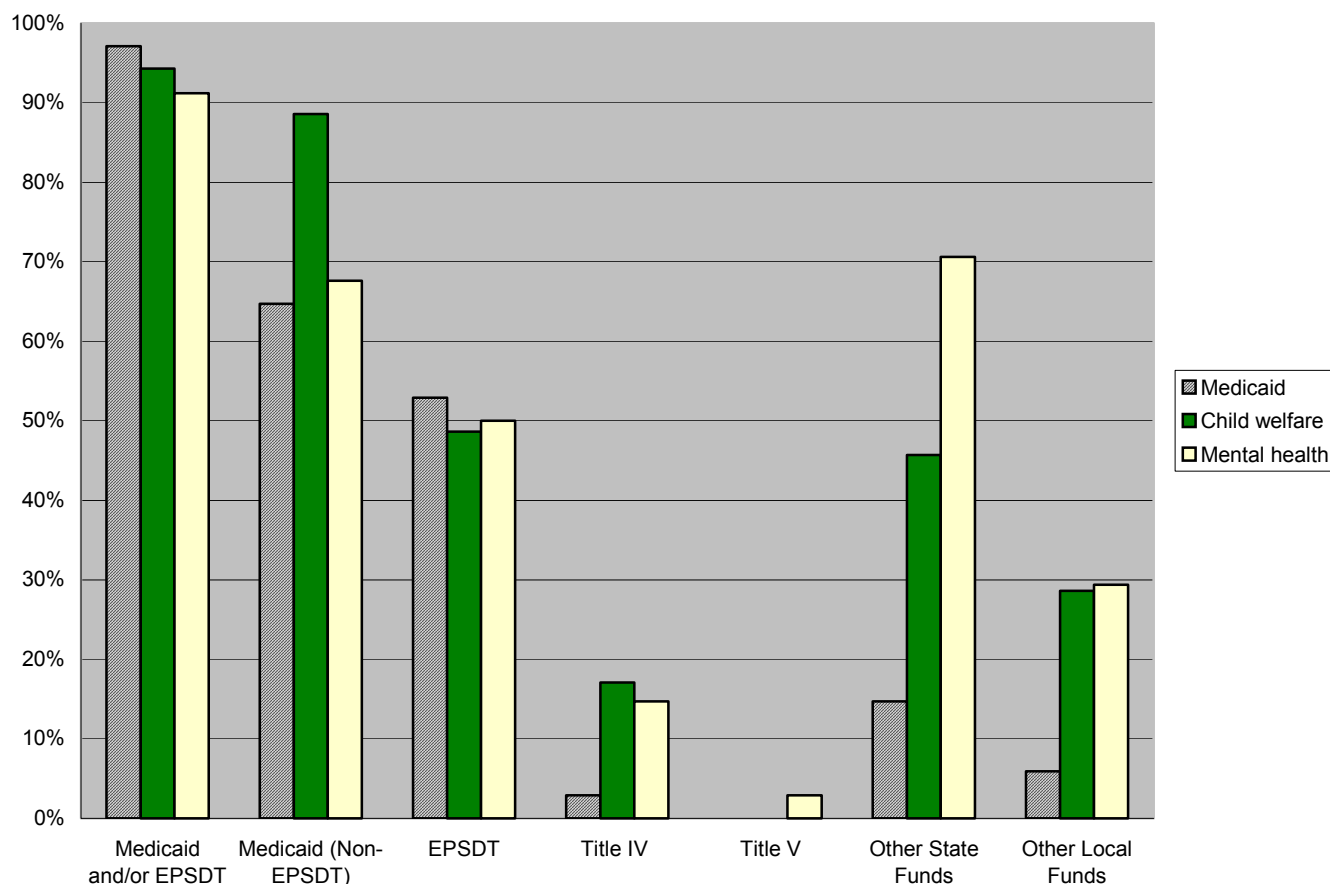
about 13 percent of state Medicaid and 20 percent of child welfare agencies. Yet federal regulations permit Medicaid reimbursement of case management for children in foster care for those care planning and referral services that are not Title IV-E eligible (HHS 2001).

Figure 3 compares responses from Medicaid, state child welfare, and state mental health agencies on mental health assessments. About one-third of state child welfare agencies (29 percent) and mental health agencies (29 percent) routinely use local funds to pay for mental health assessments. A larger proportion of agencies use state funds for these services.

Some Medicaid agencies appear generally unaware of these state and local expenditures on core services. Responses about how well Medicaid and EPSDT funding cover core services differ in many states between Medicaid agencies and child welfare agencies. For example, few Medicaid agencies report that state or local funds are used for mental health assessment, or for ongoing mental health treatment. Yet many mental health and child welfare agencies report using state or local funds.

A number of agencies report that Medicaid reimbursement is inadequate for essential services to foster children. Approximately 61

Figure 3 Routine Funding Sources for Mental Health Assessments, As Reported by State Medicaid, Child Welfare, and Mental Health Agencies



Source: UCLA calculations from the 1999/2000 Assessment of Factors Influencing the Adequacy of Health Services to Children in Out-of-Home Care

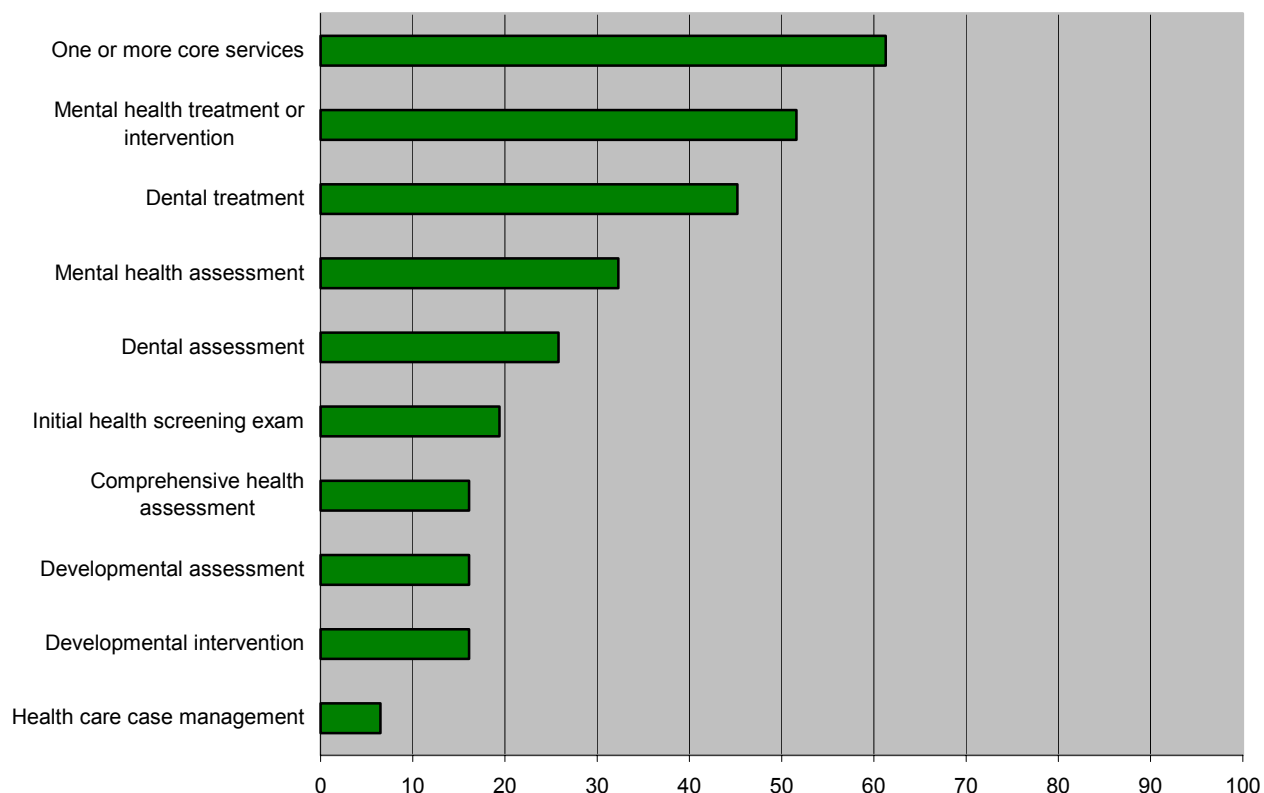
Note: Shows percentage of agencies that report routine use of a funding source to pay for mental health assessments for foster children in their state. Based on responses from 34 Medicaid agencies, 35 state child welfare agencies, and 34 state mental health agencies. Agencies can identify multiple funding sources for a given service. Category of "Medicaid and/or EPSDT" is a composite denoting use of Medicaid, EPSDT, or both.

percent of child welfare agencies routinely use child welfare funds to supplement at least one essential service (**Figure 4**). Many state child welfare and mental health agencies say that they supplement Medicaid payments for dental and mental health care. Among state mental health agencies, 70 percent use their own funds for mental health services. Among child welfare agencies, about 91 percent say that insufficient Medicaid coverage causes use of their own child welfare funds for mental health services. Of these agencies, most do this occasionally rather than as a rule. Child welfare agencies supplement several types of services more than others. Over half (52 percent) routinely supplement mental health treatment costs. More states supplement treatment and mental health services than screening and assessment services.

Medicaid Managed Care and Payment Systems of Child Welfare Services

States can increase accountability for access and quality through managed medical and behavioral health services contracting. Managed care organizations may also provide more care coordination than has been traditionally accessed by children under fee-for-service Medicaid. Yet the degree to which managed care arrangements meet the complex needs of vulnerable children has not been rigorously evaluated. Prior studies suggest that states with fee-for-service Medicaid generally have greater flexibility in the ways that children receive care and how payment is arranged. Under managed care payment arrangements, children may encounter multiple authorization requirements from the health plan and medical groups. In

Figure 4 Use of Child Welfare Funds to Supplement Medicaid Payments



Source: UCLA calculations from the 1999/2000 Assessment of Factors Influencing the Adequacy of Health Services to Children in Out-of-Home Care

Note: Shows percentage of state child welfare agencies that report routine use of child welfare funds to supplement Medicaid payments for specific services to foster children in their state. Category of "one or more core services" indicates supplementation of at least one of the listed services. Based on responses from 31 state child welfare agencies.

addition, those states that continue to maintain fee-for-service administrative claims data may have better capacity to monitor the timing and volume of services provided.

Our findings show that a significant proportion of states with Medicaid managed care cover the initial health screening assessment and the comprehensive exam under capitation for a foster child enrolled in managed care. Of the 25 state Medicaid agencies reporting some use of managed care for children in foster care, about 68 percent include the initial health assessment exam within the capitation rate, and 60 percent include the comprehensive health assessment. Somewhat fewer state child welfare agencies (48 percent) say that capitation rates include the initial screening exam. This suggests that not all child welfare agencies are aware that providers would not receive additional payment for screening exams needed for children entering placement. If child welfare agencies are not aware of this potential payment issue, then it is unlikely that they are monitoring the impact for providers and for children's access to the services.

Expansion of managed care can impair the Medicaid program's ability to track service use and timing of services for children in foster care through fee-for-service claims data. Among the 30 Medicaid agencies that responded to a survey question on managed care and data availability, most (69 percent) report no overall impact. About 17 percent say that Medicaid managed care worsened their ability to monitor use of EPSDT/Medicaid services. The remaining 14 percent say their ability improved. Few state Medicaid or child welfare agencies are able to report utilization measures such as percentage of children receiving an initial screening exam or a comprehensive health assessment. This includes states with managed care as well as those with traditional fee-for-service systems. Given the ongoing transition to Medicaid managed care and the potential for capitated payment to limit availability and access to certain kinds of providers, more information is needed to understand the impact of these delivery changes for access to health and mental health services.

DISCUSSION

While Medicaid is the primary payment source for health and mental health services to children in foster care, this study shows that there are several ways in which Medicaid programs could improve coverage and payment for essential services. There are gaps in coverage, services that are not being reimbursed, and other administrative problems that result in incomplete coverage. Moreover, child welfare and mental health agencies charged with assuring that children in foster care receive appropriate, timely, and high quality health services report difficulty paying for needed services. This shows that states may be having difficulty implementing the ASFA requirement to promote children's well-being.

Few states automatically extend Medicaid eligibility to all children entering foster care. While states have the option of establishing presumptive eligibility for children once separated from the parent, under current federal policy they would require a federal waiver to limit this eligibility option to children in foster care (Schneider and Fennel 1999). Conferring presumptive eligibility for all children would streamline eligibility and potentially reduce the administrative resources expended in determining eligibility. This could also minimize use of state and local funds for Medicaid-covered services. Another targeted eligibility option is providing Medicaid to non-Title IV-E children in foster care (including kinship care) once in placement (Schneider and Fennel 1999).

Suboptimal interagency communication is suggested from information collected in the survey. State Medicaid and child welfare agencies report different understanding of their own state's funding patterns and specific Medicaid policies. This includes presumptive eligibility policy, the extent to which Medicaid funds are covering all needed health and mental health services, and the use of Medicaid and state/local funds for services to foster children. Findings show that not all child welfare agencies understand technical details about when and how children in their care become eligible for Medicaid in their state. These differences show

that communication between state Medicaid and state child welfare agencies can be improved on technical eligibility details and on the process by which services are billed and reimbursed.

The CFSR process led by the state child welfare agency is one new vehicle for sharing technical knowledge and experiences between state child welfare and Medicaid agencies. An increasing number of state child welfare agencies have developed their initial Child and Family Services Plan (CFSP) as part of the new child welfare review process. The systemic assessment component of these plans could be expanded to also include a detailed assessment of Medicaid funding issues. The plan can also be used to reconcile discrepancies between presumed and actual eligibility and coverage. Knowledge among key state agencies about payment sources and their adequacy is an important measure of performance for this review process.

Although Medicaid managed care expansions may complicate pre-existing data reporting problems with Medicaid/EPSDT, few states report that data reporting has changed since the managed care expansion. Tracking of total payments and services received by children in foster care continues in most states. However, our findings also show that many states cannot easily produce basic utilization measures such as the percentage of children receiving comprehensive health evaluations. These measures are important for monitoring performance and tracking improvement over time.

This study provides more detail from multiple state agencies involved in delivery of health services to children in foster care than has been available until now. However, the study does not evaluate all relevant Medicaid policies and procedures on funding of health care to children in foster care. More information on eligibility, use of managed care, and funding would be useful to inform state policy. It is important to note that our findings of state and local expenditures do not imply that child welfare and mental health agencies should reduce their investment of resources in services to foster children. Instead, findings highlight areas where resources could be redirected to maximize the federal share of states' expended

resources. The surveys also do not ascertain the volume of services or define "routine" use of state and local funds in terms of total non-Medicaid costs. These are questions for future study.

KEY RECOMMENDATIONS AND ACTION STEPS

1. Detail How Medicaid Funds Can Be Used to Fully Implement the CWLA-AAP Standards

The federal agencies that administer child welfare, child health, mental health, and developmental services could convene to review the CWLA-AAP standards as they relate to these programs. The ACF, MCHB, and Centers for Medicare and Medicaid Services (CMS) could engage in a federal level discussion about how Medicaid and EPSDT can be used to achieve child welfare and ASFA goals. This would include a "roadmap" on state options for using Medicaid. Joint letters from CMS and ACF could clarify options for Medicaid eligibility, EPSDT content and requirements, and mental health services within EPSDT that would be consistent with CWLA-AAP standards.

The Medicaid program should be reimbursing almost all of the health and mental services needed by children in foster care, including coordination and referral services. Yet states are using a variety of non-Medicaid funds for health services to children entering foster care, in foster care, and exiting foster care. While Medicaid agencies report that most essential health services are covered by their Medicaid/EPSDT programs, child welfare and mental health agencies are using state and local funds to cover needed services and are supplementing Medicaid using their own funds. This suggests that states are not optimally accessing the federal matching dollars that are available. In addition to findings about Medicaid from this study, a recent National Academy of State Health Policy (NASHP) report shows different interpretations across state agencies of what EPSDT covers and what AAP and CWLA recommend (Rawlings-Sekunda 1999). Routine use of multiple funding streams can complicate the service delivery process. Federal letters jointly issued from ACF and CMS on services

could improve access to reimbursable Medicaid services. For example, the joint policy letter on case management and targeted case management and related Title IV-E policies (CMS, 2001) may address our findings that only 25 state child welfare agencies report knowing whether health care case management is reimbursed in their state and not all (80 percent) say that Medicaid routinely reimburses those services in their state. This would ensure that states are using the most effective and efficient funding mechanisms for health and mental health care. Other studies suggest that child welfare caseworkers lack the training and experience to help children in foster care access all needed services (Halfon et al. 2002b).

It is not clear from the surveys how much of the variability in funding sources stems from Medicaid eligibility among foster children and how much is caused by incomplete coverage of costs for covered benefits to Medicaid-enrolled children. Eligibility and payment rates are not controlled completely by state Medicaid programs and instead are subject to state legislative policy. The adequacy of Medicaid coverage and payment rates for children in foster care is an important issue for state legislatures.

2. Assess Medicaid Coverage and Payment Adequacy in Child and Family Service Reviews

Child welfare agencies now have greater opportunity to collaborate with their state's Medicaid agency to address and improve financing issues. Incorporating an even more comprehensive assessment of benefits, access, funding sources, and payment adequacy into child welfare CFSPs could stimulate improvement in the states.

State child welfare agencies are developing and implementing five year comprehensive Child and Family Services Plans (CFSP) for their states. State plans must include specific, measurable objectives that will be undertaken to achieve the goals set for children, youth and families. Each state's capacity to deliver services leading to improved outcomes for children and families is to be periodically examined and improved.

Systemic factors for states include information systems, the array of services, and agency responsiveness to the community, among others (HHS 2002). Involving other state agencies such as the agency responsible for Medicaid in the CFSP helps states meet the plan requirements for external stakeholder consultation. Medicaid policies also drive many health care access and availability issues for children in foster care. These policies must be part of an effective improvement plan. The Children's Bureau in ACF is also providing technical assistance to states so they can achieve goals adopted in the CFSP. A greater focus on Medicaid and health care financing could be incorporated into the technical assistance that is offered to states through ACF.

3. Expand Medicaid Eligibility at Placement and Exit from Foster Care

Attention to post-placement eligibility policies is increasing following 1999 legislation to expand Medicaid eligibility for emancipating adolescents. Extending Medicaid eligibility following exit from foster care to all children for an established time period (e.g., one year) would ensure that health and mental health improvements achieved in foster care do not diminish upon return to the home.

Few state Medicaid agencies automatically extend Medicaid for any period of time to children exiting placement. Extending Medicaid for a defined period is important for children who would be uninsured or have incomplete health coverage upon leaving foster care. The health and mental health benefits under Medicaid may be necessary to provide the necessary scope and depth of services needed. Guaranteeing Medicaid eligibility for a defined period to children leaving foster care would help ensure that improvements in health and mental health during a stay in foster care are not diminished due to discontinuation of ongoing services. Continuous eligibility for one year post placement for children who spend a defined period of time in placement (recognizes that some children have very short foster care stage) would ensure continued access to needed services.

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ENDNOTES

ⁱ New Medicaid regulations extend eligibility for adolescents who emancipate from foster care. Federal legislation enacted in 1999 gives states the option of extending Medicaid eligibility for children leaving placement at emancipation age (HHS 2000). Because regulations were issued after surveying was complete, these eligibility policies are not reflected in state policies reported here.

ⁱⁱ Because state Medicaid programs can reimburse some covered benefits for children through either Medicaid or EPSDT, we create a composite measure of Medicaid/EPSDT to show use of Medicaid funds. Title IV of the Social Security Act includes Title IV-E which provides funds to states for child welfare services and Title IV-B which provides funds for foster care maintenance payments. Title V of the Social Security Act includes Maternal and Child Health Block Grant funds including support for systems and direct services to children with special health care needs.

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This brief presents findings from the 1999-2000 Assessment of Factors Influencing the Adequacy of Health Services to Children in Out-of-Home Care. Information was gathered from state Medicaid, child welfare, mental health, and child health agencies as well as from counties with the largest child welfare populations. Surveys focused on policies of state and local child health, mental health, Medicaid, and child welfare agencies that affect the health and mental health care provided children in foster care. Other policy briefs in this series focus on use of standards for health services, the role of child health agencies, and mental health services. This analysis and the study were funded by the Maternal and Child Health Bureau (MCHB) under a cooperative agreement to the National Center for Infant and Early Childhood Health Policy (MCU-069385-02-01, 1-U05M-MC-00001:01) at UCLA. The National Center supports federal, state and local MCH in promoting a broad and integrated early childhood agenda through strategic planning and policy analysis to support early childhood system building.

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